

REPORT OF THREAT OF HARM TO SELF OR OTHERS
CHILDREN'S REVIEW PROGRAM (CRP)

FAX TO: COUNTY OF CHILD'S CURRENT RESIDENCE, CHILD'S SSW, & REGIONAL CRP LIAISON
(Please Print. Use One Per Child.)

Report Date: _____

1.

Child's Name (One (1) form per child)	DOB	Age	Sex	Race

2.

Child's Current Caretaker		Child's Current Address		
City	State	County	Zip	Phone

3. What is the child reporting? (Check all that apply.)

☐ Harm to self ☐ Harm to others ☐ Other: _____

4. Describe in detail the threat of harm to self or others reported by the child.



5. Caretaker/authority notified to ensure safety of child(ren):

Caretaker Name	Phone	Address (Street, City, State)

6.

Interviewer's/Reporter's Name & Title	Phone	E-Mail

DCBS RESPONSE TO CRP FROM COUNTY OF INCIDENT

Per SOP 7E.2.7, DCBS has 10 working days to respond to this report. Responses will be sent to the attention of the Children's Review Program – Quality Assurance Unit, P.O. Box 13520, Lexington, KY 40583-3520. Fax (859)225-3605 & Phone (859)455-7452.

I acknowledge that a "Report of Threat to Harm Self or Others" was received by this office.

Name & Title of DCBS Responding Staff	Today's Date	Phone	E-Mail